STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969117	**02/02/2018**
NAME OF PROVIDER OR SUPPLIER **MARKET STREET VIERA**	STREET ADDRESS, CITY, STATE, ZIP CODE **6845 MURRELL RD** **MELBOURNE, FL 32940**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

Complaint Investigation #2017012748 was conducted on , , and . Market Street Viera, License #12935, had deficiencies at the time of the investigation.

0007 - Admissions - Criteria - 429.26(11) FS; 58A-5.0181(1) FAC

Based on record reviews and interview, the facility admitted a resident who exceeded the admission criteria (#1).

Findings:

Review of the facility's license revealed a standard and Limited Nursing Service (LNS) license was held by the facility.

Resident #1's record revealed she was admitted to the facility on . Her admission health assessment form 1823, dated on , indicated that she required total assistance with all of her Activities of Daily Living (ADLs) and with transfers, which exceeded the admission criteria.

A facility care plan, dated on , indicated that she required total assistance with bathing, dressing, , and toileting.

On at 4 p.m., the director of clinical operations confirmed the findings.

Class III

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on record reviews and interview, the facility failed to ensure a resident had a face-to-face medical examination by a health care provider after a significant change (#3).

Findings:

On at 10 a.m., nurse A identified resident #3 and said she received a Limited Nursing Service (LNS) for a , on her .

Resident #3's record revealed she was admitted to the facility on . Her most recent health

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SUMMARY STATEMENT OF DEFICIENCIES
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assessment form 1823 was dated on .

A LNS progress note, dated on , indicated that she had a -2 , on her right and a health care provider was notified.

Resident #3's record did not contain a new health assessment form 1823 to indicate she had a face-to-face medical examination by a health care provider when she developed the , , which was a significant change.

On at 2 p.m., nurse A said a new health assessment form was not completed, as required.

Class III

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on record reviews and interviews, the facility failed to intervene when a resident experienced a weight loss (#2), failed to document and notify a health care provider when a resident was sent to the hospital (#2), failed to intervene when 2 of 2 sampled residents experienced multiple (#2 & 3), and failed to prevent the development of a , for 1 of 2 sampled residents (#1).

Findings:

1. Resident #2's record revealed that on at 10 p.m., he was found on the floor. The documented intervention was to look at the position of the bed in his .

On at 9:40 p.m., he was found lying on the floor.
On at 8 p.m., he was found on the floor. The documented intervention was to refrain from putting him to bed before 9 p.m., and to keep him within eye view after dinner.
On at 9:30 p.m., he slid out of his wheelchair and onto the foot pedals of the wheelchair, and was lowered to the floor.
On at 12:30 a.m., he was lying on his right side on the floor next to his bed. Redness was noted to his left , thigh.
On at 11:10 p.m., he was found on the mattress on the floor.
On at 8:30 p.m., he slid out of his chair in the common area and sustained two to his left hand.
On , a hospice order was received to place him in high traffic areas while awake , provide adequate response time to his needs, educate him not to lean forward to reach while in his wheelchair,

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SUMMARY STATEMENT OF DEFICIENCIES
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and offer him frequent toileting.
On at 11:20 a.m., he was found on the floor.
On at 9:42 p.m., he slid out of his wheelchair while watching a movie. He received a 1-inch laceration to his left parietal part of his head. He complained of head pain. The was witnessed.
On at 12:30 p.m., he was watching a movie in the common area and slid out of his wheelchair to the floor. His foot pedals were off of the wheelchair at the time.
On at 4 p.m., he sat by the nurse's office and slid out of his wheelchair to the floor.
On at 11 p.m., he was found on the floor. His left arm was wrapped around the bed rail. He denied pain but grabbed at his left wrist.
On at 2 p.m., he slid out of his wheelchair. An anti-slip seat cushion was ordered for his chair.
On at 1 p.m., he had a witnessed in the dining . He sustained a laceration to his forehead. He was sent to the hospital and returned to the facility on at 6:10 p.m. with to his forehead.
On at 11:50 p.m., he was found on the floor on his left side. He sustained a small to his left elbow.
On at 5:15 p.m., he tried to get out of bed without assistance, backward, and struck his head on the bed rail. He sustained a laceration to his head and was sent to the hospital. The was witnessed.
On at 1 p.m., he returned from the hospital.
On at 9:05 p.m., he slid out of his wheelchair onto his .
On at 3:40 p.m., he was observed on the dining . He had a laceration over his right upper eye. He was sent to the hospital and returned with to his right forehead.
On at 6:43 p.m., he slid out of his wheelchair onto the floor on his .

The documentation in the record of resident #2 indicated he had a total of 19 between and , and the facility documented interventions to prevent further following only two of those .

During an interview with the executive director on at 12:45 p.m.,, said the facility had no documentation to indicate additional interventions were implemented to prevent resident #2 from falling.

2. Resident #3's record revealed she was admitted to the facility on . A health assessment form 1823, dated on , indicated she had a diagnoses of , muscle , lack of coordination, Right hip , , and . She had poor insight and she was unaware of objects and her environment. On she was prescribed .

Review of the facility incident reports revealed that on at 4 p.m., she was observed on the floor

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SUMMARY STATEMENT OF DEFICIENCIES
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in the Plaza outside of the Blossom unit.
On at 12:45 p.m., she was found on the floor in her .
On at 6:35 p.m., she was found on the ground in the courtyard. She had a bloody nose and a bump above her right eyebrow. 911 was called and she was transported to the emergency (ER).
On at 6 a.m., she sat in a chair with on her forehead. She said that she . She was sent to the hospital. An ER physician record, dated on , indicated that she had right wrist pain and a right wrist . The age of the was unknown. A , was prescribed.
On at 9:45 p.m., she sat on the floor in her . She sustained a laceration to her head and she was sent to the hospital.
On at 6:50 p.m., she was found on the floor in the dining area.
On at 4 p.m., she was observed on the floor by her bed.
On at 2:45 a.m., she was found on the floor in her . She was out of her mouth, had a on her left arm, and a scratch to her left hand. She was sent to the hospital.
On at 2:30 p.m., she sat in a chair in the dining slid to the floor. The documented intervention was to offer her more fluids.
On at 10:30 a.m., she was found on the floor by her bed. She complained of hip pain and sustained a laceration to her right outer eyelid. She was sent to the hospital.
On at 10 a.m., she was observed in the outside courtyard in the flower garden laying on her right side.
On at 12 a.m., she was found on the floor by a caregiver. She yelled out in pain when her right hip and leg were moved. She was sent to the hospital via 911. A hospital history and physical, dated on , indicated she had a right hip .
On at 1:30 p.m., she returned from the hospital.
On , she was observed on the floor in the TV area. She complained of right hip pain and was sent to the hospital.

The documentation resident #3's record indicated that she had a total of 13 between and but the facility's documentation indicated an intervention was implemented only after one of those , which included a right hip following one of the .

During an interview with the executive director on at 12:50 p.m., she said the facility had no documentation to indicate additional interventions were implemented to prevent resident #3 from falling.

3. Resident #1's record revealed she was admitted to the facility on with a diagnoses of , , , , Incontinence, Gait , , , , , , , and D deficiency. She was totally dependent with all of her Activities of Daily Living (ADLs.)

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
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SUMMARY STATEMENT OF DEFICIENCIES
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A facility care plan, dated on , indicated she was to go back to bed after meals to help with the healing process and she was to be turned and positioned every two hours.

A progress note, dated on at 2:30 p.m. indicated she was admitted to the facility with three wounds to her . Home health services were ordered by a health care provider. A home health start of care assessment, dated on , indicated that she had a on her left . A home health visit note, dated on , indicated that her and the back of her thighs were cherry red in color and blanchable. A facility note, dated on at 6:45 p.m., indicated that a hospice nurse observed reddened areas on her and recommended repositioning on her right and left sides during her time in bed, to refrain from placing her on her back, recommended that she be placed back into her bed after meals to relieve pressure.

A home health note, dated on , indicated that her left measured 0.2 centimeters (cm.) by 0.2 cm. by less than (<) 0.1 cm., and she had a to her that measured 1 cm. by 0.5 cm. by 0.2 cm. On , a health care provider order was received to place her in bed after each meal.

A progress note, dated on , indicated that she was placed back into bed after meals and she was turned and repositioned every 2 hours. A progress note, dated on at 2 pm, indicated that she was placed back in bed after meals and turned and positioned every 2 hours.

A home health visit note, dated on , indicated that her and the back of her thighs were purple in color and blanchable.

A progress note, dated on at 3 p.m., indicated that she was placed back into bed after meals and turned and positioned every 2 hours.

A home health visit note, dated on , indicated that her measured 1 cm. by 1 cm. by 0.3 cm. with undermining of 0.2 cm. at 12 o'clock. "Undermining is caused by erosion under the edges, resulting in a large with a small opening....Undermining is measured directly under the edge with a probe held almost parallel to the surface, stopping when resistance is felt. The distance from the probe tip to the point at which the probe is level with the edge represents the amount of undermining present. Clock terms can also be used to describe the location of undermining." (woundsource.com).

A home health discharge assessment, dated on , indicated that her measured 1.7 cm. by 1.5 cm. by 0.3 cm., and she had a to her left that measured 2

cm. by 2 cm. by 0.1 cm. The assessment also indicated that she was admitted to home health with a to her left that healed but had reopened.

Review of a resident service sign-off form revealed 2017, 2017, and 2017 were represented on the form. The services were not signed off as being completed on , , , and .

On at 4:15 p.m., the director of clinical operations said the service sign-off form was where the staff signed to indicate the facility care plan was followed for resident #1. She confirmed there were blanks on the form.

4. Resident #2's record revealed he was admitted to the facility on . A health assessment form 1823, dated on , indicated he had a diagnoses of , and . A progress note dated on indicated he recently returned from a hospital stay. The record did not contain any documentation to reflect when he was sent to the hospital or that a health care provider was notified.

On at 12:35 p.m., the executive director said resident #2 was sent to the hospital for . She confirmed the record did not contain documentation to indicate he was sent to the hospital, and did not contain documentation to indicate a health care provider was notified when he was sent to the hospital.

A hospital discharge summary report that was dated on indicated he was admitted to the hospital on and discharged on . His discharge diagnoses was and Severe . He was brought in to the emergency to possible , during a lunch meal.

5. Review of the admission health assessment form 1823 for resident #2, dated on , revealed his admission weight was 125.2 pounds (lb.) His diagnoses were , and .

Review of his weights that were obtained by the facility revealed the following:
In 2017, he weighed 112 lb.
In 2017, he weighed 105 lb.
In 2017, he weighed 110 lb.

A note written by a hospice nurse practitioner and dated on indicated that his appetite was poor, his food intake was 20%, and his weight went from 140 lb. to 115 lb.

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Resident #2's record did not contain documentation to indicate the facility intervened to prevent further weight loss.

On at 12:40 p.m., the executive director confirmed the findings.

Class II

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observations, record reviews and interviews, the facility failed to provide a resident with a therapeutic diet as ordered by a health care provider (#5), and failed to provide the proper liquid consistency as ordered by a health care provider for 2 of 2 sampled residents (#2 & 5.)

Findings:

1. Resident #2's record revealed he was admitted to the facility on with a diagnoses of , and . On , an order was received from a health care provider for resident #2 to receive nectar consistency liquids.

On at 2:20 p.m., a progress note indicated that he aspirated during lunch. The Heimlich maneuver was performed by staff. A modified swallow study was conducted on . The recommendation from the results of the study was that he receive a puree diet with nectar consistency liquids.

A face-to-face visit note, dated on and conducted by a nurse practitioner, indicated that he had a diagnoses of .

2. Resident #5's record revealed she was admitted to the facility on with a diagnoses of , and a . Her admission health assessment form 1823, dated on , indicated that her diet was mechanical soft with nectar consistency liquids.

On at 11:08 a.m., the dietary manager said resident #2 was prescribed thickened liquids, and resident #5 was prescribed a mechanical soft diet with thickened liquids.

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Observations made during the lunch meal on at 12:30 p.m. revealed resident #2 was served a thin drink, and resident #5 was served salad, uncut beef tips, and a thin drink. Both residents #2 and #5 coughed when they drank the thin liquid.

On at 12:35 p.m., the dietary manager confirmed that resident #5 was served a regular consistency meal.

On at 12:40 p.m., caregiver C said the thickener powder was provided to her by the nurse. She poured an amount of the powder into the liquids that she believed was enough to thicken them. She did not know the specific liquid consistency that was prescribed for either resident #2 and #5.

On at 12:58 p.m., nurse A said she brought the thickener powder to the caregivers, who knew how many scoops to use, and just gauged on their own how much thickener powder to use.

On at 1:10 p.m., caregiver B said the nurse provided her with the thickener powder, and she used a spoon to place one scoop into the liquid. She did not know exactly how much thickener powder to use.

On at 3:30 p.m., the memory care director said the nurse poured some of the thickener powder into a cup and then gave it to the caregivers.

On at 3:45 p.m., observations made of resident #5 revealed she was served ice cream, which becomes a thin liquid when it melts. The executive director confirmed she was served ice cream.

Class II